State of New Hampshire
Board of Pharmacy
121 South Fruit Street
Concord, NH 03301-2412
Tel.: (603) 271-2350 Fax: (603) 271-2856
Website: www.nh.gov/pharmacy/

REGISTRATION FEE:
$750.
Submit with Check or Money Order Payable To:
Treasurer, State of New Hampshire

NON-RESIDENT / MAIL-ORDER PHARMACY APPLICATION FOR PERMIT
APRIL 1, 2015 – DECEMBER 31, 2015 REGISTRATION PERIOD

☐ Check here if this application is being submitted as part of a ***change of ownership*** for a current NH registered mail-order pharmacy. If so, enter current NH Registration # **NR**_____

Pharmacy Name		
Pharmacy Street Address		
City	State	Zip Code

Direct Telephone Line To Pharmacist (For Board Inquiries)	Pharmacy Fax Number	Toll-Free Phone Number For Use By NH Residents
( )	( )	( )

Pharmacy E-Mail Address:	Pharmacy Web Page Address

Pharmacy Type (Check All That Apply):

☐ Community Pharmacy ☐ Home Infusion Pharmacy ☐ Long Term Care Pharmacy ☐ Research/Investigational
☐ Charitable Dispensing ☐ Nuclear Pharmacy ☐ Call Center ☐ Other *(Describe Below):*
☐ Central Prescription Processing **(Must Have Copy of Quality Assurance Program Available Upon Request)*

Name Of Pharmacist-In-Charge	Pharmacist License Number	State Of Issue

Pharmacy Hours		
Monday -Friday (Open – Close):	Saturday (Open – Close):	Sunday (Open – Close):
Hours Toll-Free Telephone Service Is Available		
Monday -Friday (Open – Close):	Saturday (Open – Close):	Sunday (Open – Close):

Type Of Ownership

☐ Individual Owner/Trustee/Receivership ☐ Partnership ☐ Corporation / LLC ⇒ *State Of Incorporation*:

Name Of Parent Company / Corporation / Owner	Telephone Number
Corporate / Owner's Mailing Address	

*** If a Corporation, attach a copy of the *Certificate of Incorporation (NOT Articles of Incorporation)* from the State Where Company is Incorporated.**

*** If a Corp., Limited Liability Company (LLC), Partnership, or Sole Proprietorship, Enter You Federal Tax ID#:** _____

Types of Prescription Items Being Shipped To New Hampshire Residents:

☐ Non-Controlled Drugs ☐ Controlled Drugs ☐ Prescription Devices ☐ Prescription Diabetic Supplies
☐ None (Non-Dispensing) ☐ Non-Sterile Compounded Drugs ☐ Other *(Describe):*

☐ Sterile Compounded Drugs * *If shipping Sterile Compounded Products to NH Residents, you must attach items 1-5; additionally, by signing this application you acknowledge that the pharmacy has item #6 on hand and available upon request:*

1. Any and all GAP analysis reports related to the pharmacy done within the last twelve (12) months;
2. Any and all certification documents on compounding equipment done within the last six (6) months;
3. An inventory listing of any / all products shipped into the State of New Hampshire within the last six (6) months, including product, quantity, location of shipment, and date of shipment;
4. Any Department of Health and Human Services, Food and Drug Administration Inspection Reports (Form FDA 483) issued within the last twelve (12) months and any responses submitted to these agencies by the pharmacy;
5. Any state inspection reports issued within the last eighteen (18) months and any responses submitted to these agencies regarding the inspection reports by the pharmacy; and
6. The pharmacy's policies and procedures on sterile compounding. *(Do not attach – but must be available upon request).*

APPLICATION CONTINUED ON OTHER SIDE

Has the license/registration of this pharmacy ever been suspended, revoked, denied, voluntarily surrendered, placed on probation, or otherwise disciplined by any state or federal licensing/regulatory board/agency? ☐ Yes* ☐ No *If yes, attach explanation and copy of legal documents.

Have any of this applicant's owners, corporate officers, partners or pharmacists ever been found guilty of a felony in connection with the practice of pharmacy or distribution of drugs? ☐ Yes* ☐ No *If yes, attach explanation and copy of legal documents.

Is the pharmacy owned by an individual licensed to prescribe medicine, or does a prescriber (or a prescriber's immediate family member) have a majority/controlling interest in the pharmacy? ☐ Yes * ☐ No * If yes, what percentage is owned by a prescriber/prescriber's immediate family? _____%

Does the pharmacy have comprehensive liability insurance coverage? ☐ Yes ☐ No* *If no, please attach explanation.

ATTACHMENTS, ATTESTATION & SIGNATURE (All items must be initialed; if #2 and #8 do not apply you must write 'N/A').
Be sure to include all required attachments with your application:

As Pharmacist-In-Charge, I confirm the following (must initial each item), and I sign/date this application under penalty of perjury:

_____ 1. Copy is attached of the pharmacy's current license/registration issued by the Board of Pharmacy or other state regulatory agency where the pharmacy is located (home state);

_____ 2. Copy is attached of the pharmacy's current Federal DEA Registration Certificate if shipping controlled drugs. *If not handling/shipping controlled drug, write N/A*;

_____ 3. Copy is attached of the pharmacy's most recent * pharmacy inspection report issued by the FDA, DEA, NABP, or State Board of Pharmacy where the pharmacy is located (home state) **Must have been within the past 18 months – if not, attach explanation. Your application may be placed on hold until a more recent inspection is made.*

_____ 4. Attached is a list containing the Name, Address, & Title of All Corporate Officers, Partners or Owner(s);

_____ 5. Attached is a prescription label, containing the name, address and phone number of the pharmacy, that would be used on finished prescription products mailed to New Hampshire residents;

_____ 6. One of the following *(A [Copy of current VIPPS Certificate from NABP] or B [All 4 items listed under B]):*

A. Verified Internet Pharmacy Practice Site™ (VIPPS) accreditation from the National Association of Boards of Pharmacy; OR

B. The following materials:

I. At least 2 different photographs of the actual existing exterior, including the pharmacy signage, of the building in which the pharmacy will be or is currently located;

II. At least 2 different photographs of the prescription department as viewed by an approaching patron;

III. At least 4 different photographs of the prescription department as viewed from the interior, showing the prescription compounding area, refrigerator, water facilities, and pharmaceutical inventory storage area; and

IV. Scaled drawings of the pharmacy and drug storage area (which must include square footage).

_____ 7. A sample copy of a patient medication profile / nightly prescription print-out / drug utilization review report, that must include the following information:

A. Name and address of patient;
B. Name, address and DEA registration number of the prescriber;
C. Name, strength and quantity of drug dispersed;
D. Assigned prescription number;
E. Date of original filling; and
F. Date of refill(s).

_____ 8. If shipping sterile compounded products, you must attach items 1 through 5 listed on page 1 of this application and assert that the pharmacy also has item 6 available. *If not shipping sterile compounded products, write N/A.*

I, _____, certify that the contents of this renewal are true
Pharmacist-In-Charge (Printed Name)
and correct to the best of my knowledge and belief and the above initialed items are attached as applicable.

Signature: _____ Date: _____

➔ **This application will not be accepted without a signature and date of completion and without all required attachments.**